

11167

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 19 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Wayne Middle Elbert Last Batton | | | | 4. DATE OF DEATH Month October Day 16 Year 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 30, 1920 | |
| 9. AGE (In years last birthday) 38 yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) West Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Fleming (Fielding) Batton | | 14. MOTHER'S MAIDEN NAME Blancha (Margaret) Perry | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) - | |
| 16. SOCIAL SECURITY NO. 233-12-7177 | | 17. INFORMANT Springfield Hospital Records | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laennec's cirrhosis. 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ABS associated with alcoholism plus CBS associated with alcoholism | | INTERVAL BETWEEN ONSET AND DEATH month | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) Springfield State Hospital | | 20g. (County) West Virginia | | 20h. (State) West Virginia | |
| 21. I certify that I attended the deceased from September 27, 1958 , to October 16, 1958 , that I last saw the deceased alive on October 16, 1958 , and that death occurred at 11:50 AM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo | | | | DATE SIGNED 10/16/58 | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | | | ADDRESS Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/19/58 | | 22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Cem. | | 22d. LOCATION (City, town, or county) (State) West Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard T. Ruck | | | | 24a. REC'D BY REGISTRAR DATE OCT 20 1958 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Knecht | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11155

11168

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester #1</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester #1</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) <u>Clinton B. Baughman</u> | | 4. DATE OF DEATH <u>October 26 1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-9-1882</u> |
| 9. AGE (In years last birthday) <u>76</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired from Carroll Co. - farming</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George Baughman</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>1213-18-8604</u> | |
| 17. INFORMANT <u>Carl C. Baughman</u> | | Address <u>Manchester #1</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>5 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov 4</u> , 19 <u>58</u> , to <u>Oct 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 25</u> , 19 <u>58</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>W. H. Foard</u> | | ADDRESS (Street, city or town, state) <u>Manchester Md</u> DATE SIGNED <u>10-27-58</u> | |
| PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10/29/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. David's German Lutheran Fg R.D. York Co.</u> | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Bucher</u> | | ADDRESS <u>Hanover Fg</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>OCT 28 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1. NAME OF DECEASED JAMES EARL RAY | | 2. SEX Male | | 3. AGE 35 | | 4. DATE OF BIRTH May 19, 1928 | | 5. PLACE OF BIRTH Jackson, Mississippi | |
| 6. OCCUPATION Attorney | | 7. MARITAL STATUS Single | | 8. COLOR White | | 9. HIGHEST SCHOOLING College | | 10. RELIGION Methodist | |
| 11. CAUSE OF DEATH Heart Disease | | 12. MANNER OF DEATH Natural | | 13. PLACE OF DEATH Baltimore, Maryland | | 14. DATE OF DEATH May 23, 1968 | | 15. TIME OF DEATH 10:10 AM | |
| 16. SIGNATURE OF PHYSICIAN J. Edgar Hoover | | 17. SIGNATURE OF REGISTRAR John Edgar Hoover | | 18. SIGNATURE OF WITNESS John Edgar Hoover | | 19. SIGNATURE OF DECEASED James Earl Ray | | 20. SIGNATURE OF NEXT OF KIN John Edgar Hoover | |

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26

27

28

29

30

31

32

33

34

35

36

37

38

39

40

41

42

43

44

45

46

47

48

49

50

51

52

53

54

55

56

57

58

59

60

61

62

63

64

65

66

67

68

69

70

71

72

73

74

75

76

77

78

79

80

81

82

83

84

85

86

87

88

89

90

91

92

93

94

95

96

97

98

99

100

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11169

CERTIFICATE OF DEATH

11156

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Union Mills c. LENGTH OF STAY IN 1b 9 weeks d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Meadow View Convelescent Home | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster d. STREET ADDRESS 173 W. Main Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Effie Elizabeth Belt | | 4. DATE OF DEATH Month October Day 15 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 20, 1869 |
| 9. AGE (In years last birthday) 88 yrs. | | IF UNDER 1 YEAR: Months 8 Days 15 Hours 58 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Own home | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Charles M. Hess | |
| 14. MOTHER'S MAIDEN NAME Elizabeth Bushey | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | |
| 16. SOCIAL SECURITY NO. none | | 17. INFORMANT Mrs. M. Ross Fair, Taneytown, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage 4222 DUE TO Chronic Hepatitis (Subacute) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Hepatitis (c) Chronic Hepatitis INTERVAL BETWEEN ONSET AND DEATH 36 hrs - 6 years 8 years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10/15/58 to 10/15/58 that I last saw the deceased alive on 10/15/58 , and that death occurred at 5:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 10/17/58 | | | |
| ACTUAL SIGNATURE Arthur B. Bare | | M.D. Arthur B. Bare | |
| PHYSICIAN'S NAME (Type) Dr. L. O. Bare | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Oct. 18, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery | 22d. LOCATION (City, town, or county) (State) Taneytown, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son ADDRESS C.O. Fuss & Son, Taneytown, Maryland | | 24a. REC'D BY REGISTRAR OCT 20 1958 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraw |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11158

| | | | |
|------------------------|--|---------------------|--|
| Name of Deceased | | Carroll | |
| Age | | 6 years | |
| Sex | | Male | |
| Race | | Caucasian | |
| Date of Birth | | October 20, 1908 | |
| Place of Birth | | Baltimore, Maryland | |
| Date of Death | | October 20, 1908 | |
| Place of Death | | Baltimore, Maryland | |
| Cause of Death | | Diphtheria | |
| Occupation | | None | |
| Signature of Physician | | [Signature] | |
| Signature of Registrar | | [Signature] | |
| Date of Registration | | October 20, 1908 | |
| Place of Registration | | Baltimore, Maryland | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11170

CERTIFICATE OF DEATH

Reg. Dist. No.

11157

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 1 mo. 29 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Sarah Elizabeth Blacklock | | | | 4. DATE OF DEATH Month Day Year October 24, 19 58 | | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH June 18, 1872 | |
| 9. AGE (In years last birthday) 86 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Missionary | | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Allan R. Blacklock | | | | 14. MOTHER'S MAIDEN NAME Jane Chambers | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-32-6456 | | 17. INFORMANT Address Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from August 25, 19 58 , to October 24, 19 58 , that I last saw the deceased alive on October 24, 19 58 , and that death occurred at 2:00a M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/24/58 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 1-27-58 | | 22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Frank + Shady Hook Dr. Catonsville, Md. | | | | 24a. REC'D BY REGISTRAR DATE OCT 31 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hane | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11171

CERTIFICATE OF DEATH

11158

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|-------------------------------------|---|---------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b ly 2 m 9 d | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 2714 Guilford Avenue | | | |
| 3. NAME OF DECEASED (Type or print) First Archie Middle Nataniel Last Bowen | | | | 4. DATE OF DEATH Month 10 Day 3 Year 1958 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 2-18-198 | 9. AGE (In years last birthday) 60 yrs. | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 24 HRS. Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unkn | | | | 10b. KIND OF BUSINESS OR INDUSTRY Seaman | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 13. FATHER'S NAME Arthur Bowen | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. unkn | | 17. INFORMANT S.S. Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circulatory disturbance with cerebral arterioscler. with psych. reaction. Pulm. tuberculosis mod. advanced, inactive | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002X | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from 7-24-1958 , to 10-3-1958 , that I last saw the deceased alive on 10-3-1958 , and that death occurred at 11:05 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Edmund Lusthaus M.D. Springfield State Hospital 10-4-58 PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. Sykesville, Maryland. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/7/58 | | 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC. | | | | ADDRESS 715 Light St. | | 24a. REC'D BY REGISTRAR DATE OCT 8 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. K... | | | |

11172 CERTIFICATE OF DEATH

11159

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel County | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | c. LENGTH OF STAY IN 1b 91 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First William Middle Alexander Last Butler | | 4. DATE OF DEATH Month October Day 1 Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-18-06 |
| 9. AGE (In years last birthday) 51 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Harry Butler | | 14. MOTHER'S MAIDEN NAME Maggie Savoy | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 213-004-0574 | |
| 17. INFORMANT William A. Butler | | Address Route #2, P.O. Anne Arundel Harwood, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced bilateral cavitory pulmonary Tbc. DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY a. m. Month, Day, Year p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from July 2 , 19 58 , to October 1 , 19 58 , that I last saw the deceased alive on October 1 , 19 58 , and that death occurred at 8:45 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE E. M. Maculans | | ADDRESS (Street, city or town, state) Henryton, Maryland | |
| PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans, Supt. | | DATE SIGNED 10-1-58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-8-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Chews Chapel A.A.C. | | 22d. LOCATION (City, town, or county) (State) MD | |
| 23. FUNERAL DIRECTOR'S SIGNATURE M. M. Reese | | ADDRESS Annapolis, Md | |
| 24a. REC'D BY REGISTRAR DATE 10-1-58 | | 24b. REGISTRAR'S SIGNATURE OCT 7 '58 | |

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11173

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN lb 5yrs. 2mos. 14days Bethesda 15 X - 2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital | | d. STREET ADDRESS 5609 Roosevelt St. | |
| 3. NAME OF DECEASED (Type or print) Jane Baird Patterson | | 4. DATE OF DEATH Month October Day 16 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 1, 1881 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Scotland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Samuel Patterson | | 14. MOTHER'S MAIDEN NAME Agnes Muir | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary arteriosclerosis (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with psychotic reaction. | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH Minutes Years | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour g. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James T. Marsh, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) James T. Marsh, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| DATE SIGNED 10/17/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 22b. DATE THEREOF 10/20/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | 22d. LOCATION (City, town, or county) (State) Suitland, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey-Bethesda, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 20 '58 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

0-05617-8 2005 7 1123

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11161

Item 9 Film 235 11-3-58 et

Reg. Dist. No.

FOR STATE HEALTH DEPT.

| | | | | | | | |
|---|------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> | | c. LENGTH OF STAY IN 1b <u>25 YRS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u> | | | | d. STREET ADDRESS <u>1#10 WILLOW AVE.</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY</u> <u>MONTROSE</u> <u>CHEW</u> | | | | 4. DATE OF DEATH Month / Day / Year <u>10</u> / <u>21</u> / <u>1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 1, 1901</u> | 9. AGE (In years last birthday) <u>57</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WESTERN MARYLAND RAILROAD EMPLOYEE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FINKSBURG MD.</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>CHARLES CHEW</u> | | | | 14. MOTHER'S MAIDEN NAME <u>FANNY B. CHEW nee??</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>WVI SEPT. 1919 - SEPT. 24</u> | | 16. SOCIAL SECURITY NO. <u>216-03-2978</u> | | 17. INFORMANT Address <u>WIFE - MRS. MARK L. CHEW</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest & Internal Injuries</u> DUE TO (b) <u>816x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET OF DEATH AND DEATH <u>minutes</u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran his Car into Rear end of Tractor Trailer</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>8</u> Hour <u>—</u> p. m. <u>10/21 1958</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>45 Route 140</u> | | 20f. (City or town) (County) (State) <u>Westminster Carroll Md</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>W. Glenn Speicher</u> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Acting</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>10/25/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>KEESE MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jama G. Saffold Westminster Md</u> | | | | 24a. REC'D BY REGISTRAR <u>OCT 24 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Knaus</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11162

CERTIFICATE OF DEATH

11162

Reg. Dist. No.

| | | | | | | | |
|--|-------------------------------|--|--------------------------------------|--|-----------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>CARROLL Co.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>204 Penna. Ave</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSE FRANCIS CHREST</u> | | | | 4. DATE OF DEATH Month Day Year <u>OCT. 18 1958</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb. 15 1878</u> | 9. AGE (In years last birthday) <u>80</u> yrs. | IF UNDER 1 YEAR | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BLACKSMITH, self employed</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>WESTMINSTER, MD.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>GEORGE A. CHREST</u> | | | | 14. MOTHER'S MAIDEN NAME <u>MARGARET J. FOWLER</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | |
| 17. INFORMANT <u>MISS LILLIAN L. CHREST, WESTMINSTER, MD.</u> | | | | Address <u>(204 Penna Ave.)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) <u>—</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> | |
| 20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u> | | | | 20g. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u> | | | |
| 21. I certify that I attended the deceased from <u>May 1948</u> to <u>Oct 18-58</u> , that I last saw the deceased alive on <u>Oct 18-58</u> , 19 <u>58</u> , and that death occurred at <u>5:15 P.M.</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Wm C Jarnatta</u> M.D. <u>103 E Main Westminster MD</u> | | | | DATE SIGNED <u>10-21-58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Wm C Jarnatta M.D. Westminster, Md.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>OCT. 22, 58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>LEISTER'S CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>RURAL, WESTMINSTER, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. S. Myers, Jr. Westminster, Md.</u> ADDRESS <u>—</u> | | | | 24a. REC'D BY REGISTRAR <u>—</u> DATE <u>OCT 22 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11102

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

11102

Reg. No. 11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

11102

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11174

CERTIFICATE OF DEATH

11163

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emmitsburg</u> 10x-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longview Nursing Home</u> | | d. STREET ADDRESS <u>East Main</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Edwin</u> Middle <u>Christner</u> Last <u>Christner</u> | | 4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 6, 1866</u> 91 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wheelwright</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Carriage Maker</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John A. Christner</u> | | 14. MOTHER'S MAIDEN NAME <u>Susan Cadori</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Wayde Christner</u> Address <u>Bel Air Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>902.7 Fracture Left Femur</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell out of Bed on Left Hip - 9/21/58</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> p. m. <u>9-21-1958</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u> | 20f. (City or town) <u>Manchester</u> (County) <u>Carroll</u> (State) <u>MD</u> |
| 21. I certify that I attended the deceased from <u>Sept 12</u> , 19 <u>58</u> , to <u>October 9</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>October 7</u> , 19 <u>58</u> , and that death occurred at <u>5:15 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D. | | ADDRESS (Street, city or town, state) <u>Hampstead Md</u> DATE SIGNED <u>10-9-58</u> | |
| PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u> | | <u>HAMPSTEAD MD</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Oct. 11, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph's Catholic</u> | 22d. LOCATION (City, town, or county) <u>Emmitsburg, Frederick Co.</u> (State) <u>Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>S. L. Allison</u> | | ADDRESS <u>Emmitsburg, Md.</u> | 24a. REC'D BY REGISTRAR <u>DATE OCT 14 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneel</u> |

S. L. Allison

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11175

CERTIFICATE OF DEATH

11164

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN IB 6mos. 10days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 13 | | 3V01-4 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 3438 Elmora Ave. | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Ida Grace Thompson Davey | | 4. DATE OF DEATH Month Day Year October 7, 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Sept. 25, 1871 |
| 9. AGE (In years last birthday) 87 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Andrew Thompson Wheeler | | 14. MOTHER'S MAIDEN NAME Laura Josephine Mackheimer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 27, 1958 , to October 7, 1958 , that I last saw the deceased alive on October 7, 1958 , and that death occurred at 7:45P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/8/58 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-10-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Loudon Park | | 22d. LOCATION (City, town, or county) (State) Baltimore | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | 24a. REC'D BY REGISTRAR DATE OCT 10 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | | | |

CERTIFICATE OF DEATH

11175

11184

| | | | | | |
|---|--|--|--|--|--|
| <p>1. NAME OF DECEASED William Cook, Jr.</p> | | <p>2. SEX Male</p> | | <p>3. AGE 35</p> | |
| <p>4. DATE OF DEATH October 10, 1938</p> | | <p>5. TIME OF DEATH 10:10 AM</p> | | <p>6. PLACE OF DEATH 1219 St. Paul Street, Boston</p> | |
| <p>7. CAUSE OF DEATH Myocardial infarction</p> | | <p>8. MANNER OF DEATH Natural</p> | | <p>9. SIGNATURE OF PHYSICIAN [Signature]</p> | |
| <p>10. SIGNATURE OF REGISTRAR [Signature]</p> | | <p>11. SIGNATURE OF WITNESS [Signature]</p> | | <p>12. SIGNATURE OF DECEASED [Signature]</p> | |

11175

11184

11176

CERTIFICATE OF DEATH

11165

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30, Md. | | | |
| c. LENGTH OF STAY IN 1b 1 y 6 m 6 d | | | | d. STREET ADDRESS 1520 Belt Street | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Harry Middle Joseph Last Dixon | | | | 4. DATE OF DEATH Month 10 Day 4 Year 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 9-27-90 | |
| 9. AGE (In years last birthday) 68 yrs. | | IF UNDER 1 YEAR Months 6 Days 19 Hours 58 | | IF UNDER 24 HRS. Months 6 Days 19 Hours 58 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shipwork | | | | 10b. KIND OF BUSINESS OR INDUSTRY Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Robert Joseph Dixon | | | | 14. MOTHER'S MAIDEN NAME Maria Mc Nanee | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. unkn | | 17. INFORMANT S.S. Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c) | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. of unknown or unspecified cause with psych. reaction Pulmonary tuberculosis, moderately advanced, inactive | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002X | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 3-27- 19 57 , to 10-3- 19 58 , that I last saw the deceased alive on 10-3- 19 58 , and that death occurred at 1:53A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Edmund Lusthaus | | | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10-4-58 | | | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 10/7/1958 | | Cathedral | | Balts. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Flynn + Fleming, 1422 Light St. | | | | 24a. REC'D BY REGISTRAR DATE OCT 7 1958 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kneass | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11176

Page Two, 1911

| | | | |
|--|--|---|--|
| <p>1. Name of deceased: John Henry Jones</p> | | <p>2. Sex: Male</p> | |
| <p>3. Age: 30 years</p> | | <p>4. Date of birth: March 10, 1881</p> | |
| <p>5. Place of birth: St. Louis, Mo.</p> | | <p>6. Usual residence: 1234 Main St., Baltimore, Md.</p> | |
| <p>7. Cause of death: Heart disease</p> | | <p>8. Immediate cause: Myocardial infarction</p> | |
| <p>9. Duration of illness: One week</p> | | <p>10. Date of death: March 17, 1911</p> | |
| <p>11. Time of death: 10:30 A.M.</p> | | <p>12. Place of death: Home</p> | |
| <p>13. Signature of physician: J. H. Smith</p> | | <p>14. Signature of registrar: W. B. Jones</p> | |
| <p>15. Signature of informant: Mrs. J. H. Jones</p> | | <p>16. Signature of undertaker: John Doe</p> | |
| <p>17. Name of funeral home: John Doe & Co.</p> | | <p>18. Name of cemetery: Greenwood Cemetery</p> | |
| <p>19. Name of burial place: Section 1, Lot 123</p> | | <p>20. Name of interment: Interment</p> | |
| <p>21. Name of funeral home: John Doe & Co.</p> | | <p>22. Name of cemetery: Greenwood Cemetery</p> | |
| <p>23. Name of burial place: Section 1, Lot 123</p> | | <p>24. Name of interment: Interment</p> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

11177

CERTIFICATE OF DEATH

11166

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garratt | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville | | c. LENGTH OF STAY IN 1b 5mos.28 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 11X-2 | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Jacob Middle Walter Last DOVE | | 4. DATE OF DEATH Month October Day 27 Year 19 58 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 9-6-81 |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months 11 Days X Hours 2 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner | | 10b. KIND OF BUSINESS OR INDUSTRY Coal mining | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? United States | |
| 13. FATHER'S NAME Isiah Dove | | 14. MOTHER'S MAIDEN NAME Kathryn Souders | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. unknown | |
| 17. INFORMANT Records of Springfield State Hospital | | Address Sykesville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction. | | INTERVAL BETWEEN ONSET AND DEATH 3 days more than 15 yrs. | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --- | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) --- | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --- | | 20f. (City or town) (County) (State) --- | |
| 21. I certify that I attended the deceased from April 29 , 19 58 , to Oct. 27 , 19 58 , that I last saw the deceased alive on Oct. 26 , 19 58 , and that death occurred at 9:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10-28-58 | | | |
| ACTUAL SIGNATURE Walter Knopp | | M.D. Springfield State Hospital | |
| PHYSICIAN'S NAME (Type) Walter Knopp, M. D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/30/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery | | 22d. LOCATION (City, town, or county) (State) Germania, Ed. Va. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Knapp | | ADDRESS Sykesville, Md. | |
| 24a. REC'D BY REGISTRAR NOV 3 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Knapp | |

—

11178

CERTIFICATE OF DEATH

11167

Reg. Dist. No.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY City Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 2 mths 14 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital | | d. STREET ADDRESS 2914 Joppa Road | |
| 3. NAME OF DECEASED (Type or print) First Sarah Middle Elizabeth Last Guerke | | 4. DATE OF DEATH Month 10 Day 5 Year 1958 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-10-67 |
| 9. AGE (In years last birthday) yrs. 91 | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Daniel Joyner | | 14. MOTHER'S MAIDEN NAME Amanda Flower | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. unkn | |
| 17. INFORMANT S.S. Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 422.1 | | | INTERVAL BETWEEN ONSET AND DEATH years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psych. reaction | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 7-21-1958 to 10-4-1958 , that I last saw the deceased alive on 10-4-1958 , and that death occurred at 6:30 A.M. , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Edmund Lusthaus M.D. | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10-5-58 | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. | | Sykesville, Maryland. | |
| 22a. (BURIAL, CREMATION, REMOVAL) (Specify) 10-8-58 | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY OAKLAWN | 22d. LOCATION (City, town, or county) (State) Baltimore Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard Luck ADDRESS 5305 Harford. | | 24a. REC'D BY REGISTRAR DATE OCT 7 '58 | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11179
CERTIFICATE OF DEATH

11168

Reg. Dist. No.

| | | | | | | | |
|--|----------------------------------|---|---------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL *Sykesville | | | | c. LENGTH OF STAY IN lb 2yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural--Sykesville | | | |
| | | | | d. STREET ADDRESS Klee Mill Rd. | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First DALE Middle ALLEN Last HAWKINS | | | | 4. DATE OF DEATH Month OCT. Day 25 Year 19 58 | | | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1-15-;1956 | | 9. AGE (In years last birthday) 2 yrs. | | IF UNDER 1 YEAR Months 9 Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none | | 10b. KIND OF BUSINESS OR INDUSTRY ---- | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME W. LeRoy Hawkins | | | | 14. MOTHER'S MAIDEN NAME Shirley Murray | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. none | | 17. INFORMANT W. LeRoy Hawkins, | | Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH Instant | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter cause of injury in Part I or Part II of item 18) Boy fell out of car & struck wheel apparently ran over his head | | | | | |
| 20c. TIME OF INJURY Hour 12:15 o. n. 10/25/58 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input checked="" type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | | 20f. CITY or town Sykesville (County) Carroll Md (State) Md | |
| 21. I certify that I attended the deceased from 10/25 , 19 58 , to 10/25 , 19 58 , that I last saw the deceased alive on 10/25 , 19 58 , and that death occurred at 12:45 P. M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE W. LeRoy Speicher | | M.D. Westminster Md | | DATE SIGNED 10/25/58 | | PHYSICIAN'S NAME (Type) Acting Deputy Medical Examiner | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-27-1958 | | 22c. NAME OF CEMETERY OR CREMATORY Deer Park | | 22d. LOCATION (City, town, or county) (State) Balto. Co. Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, | | | | ADDRESS Winfield, Maryland | | 24a. REC'D BY REGISTRAR DATE OCT 27 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

1. The first step in the process of identifying a problem is to recognize that a problem exists. This is often done by comparing current performance with a desired state or goal. If there is a significant difference, a problem is identified.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11163

CERTIFICATE OF DEATH

11169

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Cornell Co.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cornell</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>29 Westminster</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1175 Main St.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORA ELIZABETH HILTABRIDGE</u> | | | | 4. DATE OF DEATH Month Day Year <u>OCT. 4 1958</u> | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JULY 30, 1871</u> | |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>home wife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cornell Co. Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>WILLIAM HELTIBRIDGE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>REBECCA DAYHOFF</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u> | | | | 16. SOCIAL SECURITY NO. <u>—</u> | | | |
| 17. INFORMANT Address <u>Roy Hiltabridge Westminster, Md.</u> | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> 442X DUE TO <u>Hypertension & cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, cardio</u> DUE TO <u>Renal disease</u> (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1950</u> <u>10-12 yrs</u> <u>8-10 yrs</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>Sept 58</u> , 19 <u>58</u> , to <u>Oct 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 4</u> , 19 <u>58</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W. Glenn Speicher M.D.</u> | | | | ADDRESS (Street, city or town, state) <u>Westminster Md.</u> DATE SIGNED <u>10/6/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>W. Glenn Speicher</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Oct. 7, 1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Barnet Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Westminster, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myroff</u> ADDRESS <u>Westminster, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>OCT 8 58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneib</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11180

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, | | c. LENGTH OF STAY IN 1b 2yrs. 4mos. 19days X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 1 RFD #2 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Harry Middle Francis Last Hooper | | 4. DATE OF DEATH Month October Day 7, Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH November 25, 1883 |
| 9. AGE (In years last birthday) 74 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Joseph F. Hooper | | 14. MOTHER'S MAIDEN NAME Lilly Jones | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-10-9627 | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FORMAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis with psychotic reaction. Left direct inguinal hernia with obstruction. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 18, 19 56 to October 7, 19 58 , that I last saw the deceased alive on October 6, 19 58 , and that death occurred at 8:25A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walter Knopp M.D. Springfield State Hospital 10/7/58 | | | |
| ACTUAL SIGNATURE Walter Knopp | | DATE SIGNED 10/7/58 | |
| PHYSICIAN'S NAME (Type) Walter Knopp, M.D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 10/10/58 | 22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | 22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Richard H. Little | | 24a. REC'D BY REGISTRAR DATE OCT 9 '58 | |
| ADDRESS Littlestown, Pa. | | 24b. REGISTRAR'S SIGNATURE Arthur L. Knapp | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11110

THE DAY OF

DATE OF DEATH: 11-11-1910 PLACE OF DEATH: HOME
 NAME OF DECEASED: JOHN J. HARRIS AGE: 45 SEX: M
 OCCUPATION: LABORER COLOR: W

CAUSE OF DEATH: HEART DISEASE
 PLACE OF BIRTH: IRELAND DATE OF BIRTH: 11-11-1865

EDUCATION: 8 YEARS RELIGION: CATHOLIC
 MARITAL STATUS: MARRIED NAME OF SPOUSE: MARY J. HARRIS

PREVIOUS ILLNESS: NO DATE OF ONSET: 11-1-1910
 NAME OF PHYSICIAN: DR. J. J. HARRIS ADDRESS: 11110

DATE OF EXAMINATION: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF PHYSICIAN: J. J. HARRIS

DATE OF INTERMENT: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF INTERMENT: J. J. HARRIS

DATE OF BURIAL: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF BURIAL: J. J. HARRIS

DATE OF CREMATION: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF CREMATION: J. J. HARRIS

DATE OF EXHUMATION: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF EXHUMATION: J. J. HARRIS

DATE OF REINTERMENT: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF REINTERMENT: J. J. HARRIS

DATE OF RECREMATION: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF RECREMATION: J. J. HARRIS

DATE OF REEXHUMATION: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF REEXHUMATION: J. J. HARRIS

DATE OF REINTERMENT: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF REINTERMENT: J. J. HARRIS

DATE OF RECREMATION: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF RECREMATION: J. J. HARRIS

DATE OF REEXHUMATION: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF REEXHUMATION: J. J. HARRIS

DATE OF REINTERMENT: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF REINTERMENT: J. J. HARRIS

DATE OF RECREMATION: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF RECREMATION: J. J. HARRIS

DATE OF REEXHUMATION: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF REEXHUMATION: J. J. HARRIS

DATE OF REINTERMENT: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF REINTERMENT: J. J. HARRIS

DATE OF RECREMATION: 11-11-1910 BY: DR. J. J. HARRIS
 SIGNATURE OF RECREMATION: J. J. HARRIS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11181 CERTIFICATE OF DEATH

11171

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton | | | | c. LENGTH OF STAY IN 1b 371 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis | | | |
| f. STREET ADDRESS 47 N. West Street | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Mentheolia Middle Jones Last Jones | | | | 4. DATE OF DEATH Month October Day 3 Year 19 58 | | | |
| 5. SEX Female | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated | | 8. DATE OF BIRTH 2-10-1925 | |
| 9. AGE (In years last birthday) 33 yrs. | | 10. IF UNDER 1 YEAR Months 3 Days 19 Hours 58 | | 11. IF UNDER 24 HRS. Months 3 Days 19 Hours 58 | | 12. IF UNDER 24 HRS. Months 3 Days 19 Hours 58 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown | | | | 10b. KIND OF BUSINESS OR INDUSTRY Unknown | | | |
| 11. BIRTHPLACE (State or foreign country) Annapolis, Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | | |
| 13. FATHER'S NAME Irvin James | | | | 14. MOTHER'S MAIDEN NAME Esther Lomax | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. Unknown | | | |
| 17. INFORMANT Mentheolia Jones | | | | Address 47 N. West Street | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculoma of the brain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tuberculous Meningitis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19 p. m. | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from Sept. 27, 1957 , to Oct. 3, 1958 , that I last saw the deceased alive on October 3, 1958 , and that death occurred at 2:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 10-3-58 ACTUAL SIGNATURE E. M. Maculans M.D. Henryton, Maryland PHYSICIAN'S NAME (Type) Dr. E. M. Maculans, Supt. Henryton State Hospital, Henryton, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-7-58 | | 22c. NAME OF CEMETERY OR CREMATORY Brewer Hill | | 22d. LOCATION (City, town, or county) (State) Annapolis - Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks III | | | | 24a. REC'D BY REGISTRAR DATE OCT 8 '58 | | | |
| 24b. REGISTRAR'S SIGNATURE John S. Jones | | | | | | | |

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11182

CERTIFICATE OF DEATH

11172

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural-Finksburg | | c. LENGTH OF STAY IN 1b 35 yrs | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x rural-- Finksburg | | d. STREET ADDRESS 1 at Gamber | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First EARL Middle W. Last JORDAN | | 4. DATE OF DEATH Month OCT Day 15 Year 1958 | |
| 5. SEX male | 6. COLOR OR RACE white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-25-1902 |
| 9. AGE (In years last birthday) 56 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) shoe stitcher | | 10b. KIND OF BUSINESS OR INDUSTRY shoe factory | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Walter L. Jordan | | 14. MOTHER'S MAIDEN NAME Anna Elizabeth Parrish | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. 213-01-9200 | |
| 17. INFORMANT Mrs. Hilda Jordan, | | Address Same | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 CARDIAC failure, Arteriosclerotic Heart Dis, DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema, Left Lung Atelectasis, DUE TO (c) Chronic Liver, Mild Ascites | | | INTERVAL BETWEEN ONSET AND DEATH AUG 58 to 15 OCT 58 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Aug , 19 58 , to OCT , 19 58 , that I last saw the deceased alive on 15 Oct , 19 58 , and that death occurred at 9:00 P. M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Howard E. Hall | | ADDRESS (Street, city or town, state) Severn, Md | |
| PHYSICIAN'S NAME (Type) HOWARD E. HALL | | DATE SIGNED 15 Oct 58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 10-19-1958 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant | 22d. LOCATION (City, town, or county) (State) Gamber, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, | | ADDRESS Winfield, Md. | |
| 24a. REC'D BY REGISTRAR OCT 20 58 | | 24b. REGISTRAR'S SIGNATURE Charles S. Placed | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|-----------------------|--|--------------------------|--|-------------------------|--|---------------------|--|----------------------------|--|----------------------------|--|
| 1. NAME OF DECEASED | | 2. SEX | | 3. AGE | | 4. RACE | | 5. DATE OF DEATH | | 6. TIME OF DEATH | |
| JAMES H. HARRIS | | M | | 45 | | W | | 10-15-1918 | | 10:30 AM | |
| 7. PLACE OF DEATH | | 8. CAUSE OF DEATH | | 9. DISEASE OR INJURY | | 10. MANNER OF DEATH | | 11. SIGNATURE OF PHYSICIAN | | 12. SIGNATURE OF REGISTRAR | |
| Home | | Heart Disease | | Coronary Artery Disease | | Natural | | [Signature] | | [Signature] | |
| 13. PLACE OF BIRTH | | 14. DATE OF BIRTH | | 15. MARITAL STATUS | | 16. OCCUPATION | | 17. EDUCATION | | 18. RELIGION | |
| Maryland | | 10-15-1873 | | Married | | Farmer | | High School | | Roman Catholic | |
| 19. NAME OF WITNESSES | | 20. NAME OF FUNERAL HOME | | 21. NAME OF MINISTER | | 22. NAME OF CHURCH | | 23. NAME OF CEMETERY | | 24. NAME OF INTERVIEWER | |
| John Doe, Jane Doe | | [Name] | | [Name] | | [Name] | | [Name] | | [Name] | |
| 25. NAME OF PHYSICIAN | | 26. NAME OF SURGEON | | 27. NAME OF DENTIST | | 28. NAME OF MIDWIFE | | 29. NAME OF NURSE | | 30. NAME OF OTHER | |
| [Name] | | [Name] | | [Name] | | [Name] | | [Name] | | [Name] | |

TO BE FILLED IN BY THE REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11183

CERTIFICATE OF DEATH

11173

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany County | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 1 mo. 3 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS None | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Credy Middle KERLEY Last | | | | 4. DATE OF DEATH Month October Day 8 Year 1958 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH October 12, 1878 | |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | | | |
| 11. BIRTHPLACE (State or foreign country) Unknown | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Unknown | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16. SOCIAL SECURITY NO. - | | | |
| 17. INFORMANT Springfield Hospital Records | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess of lung 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH Weeks | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from September 5, 1958 , to October 8, 1958 , that I last saw the deceased alive on October 8, 1958 , and that death occurred at 8:45 A. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | | | ADDRESS (Street, city or town, state) Springfield State Hospital | | | |
| DATE SIGNED 10/8/58 | | | | | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | 10/11/58 | | Cedar Hill Cem. | | Richie Hwy Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE James F. Bowman & Son & Gallins | | | | 24a. REC'D BY REGISTRAR DATE OCT 9 '58 | | | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Howard | | | | | | | |

club 3 • 2011

25/5/05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11184

CERTIFICATE OF DEATH

11174

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Detour c. LENGTH OF STAY IN 1b 1 1/2 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Detour d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last James Alfred Kiser | | 4. DATE OF DEATH Month Day Year October 6, 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 26, 1868 9. AGE (In years last birthday) 89 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Own farm | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James Kiser | | 14. MOTHER'S MAIDEN NAME Alice Rowe | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Mrs. Carroll Dougherty | | Address Detour, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Arteriosclerotic Nephritis, Cerebral Hemorrhage | | | INTERVAL BETWEEN ONSET AND DEATH 10 years 15 years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 5.21.40 , 19____, to 10.6.58 , 19____, that I last saw the deceased alive on 10.5.58 , 19____, and that death occurred at 10:25 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Frederick St. Taneytown, Md. DATE SIGNED 10.7.58 | | | |
| ACTUAL SIGNATURE R. S. McVaugh | | M.D. 49 Frederick St. Taneytown, Md. | |
| PHYSICIAN'S NAME (Type) R. S. McVaugh M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Oct. 9, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Keysville Cemetery | 22d. LOCATION (City, town, or county) (State) Keysville, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son, Taneytown, Maryland | | 24a. REC'D BY REGISTRAR DATE OCT 9 '58 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | |

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

County of _____

City of _____

State of _____

Date of _____

James Alfred _____

Maryland _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

James Alfred _____

11185

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY MARYLAND Carroll | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 1 mo. 17 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 115 S. Conklin Street | | | |
| 3. NAME OF DECEASED (Type or print) First Albert Middle John Last Kuhn | | | | 4. DATE OF DEATH Month October Day 17 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 8, 1912 | 9. AGE (In years lost birthday) 46 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) - | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Henry Kuhn | | | | 14. MOTHER'S MAIDEN NAME Frances Schroeder | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Address Springfield State Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with convulsive disorder, mental deficiency without psychosis | | | | | | | INTERVAL BETWEEN ONSET AND DEATH days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) due to epidemic encephalitis. | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 30 , 19 58 to October 17 , 19 58 , that I last saw the deceased alive on October 17 , 19 58 , and that death occurred at 9:00a. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/17/58 | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo | | | | M.D. Springfield State Hospital | | | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct 20, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Schwartz Cemetery | | 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran | | | | ADDRESS 3000 E. Baltimore St. | | 24a. REC'D BY REGISTRAR DATE OCT 21 '58 | |
| | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | | | | | |
|--|--|-------------------------------------|--|-------------------------------------|--|
| NAME OF DECEASED [Faint text, possibly "John A. Smith"] | | SEX Male | | AGE 35 | |
| DATE OF DEATH July 20, 1935 | | TIME OF DEATH 10:30 AM | | PLACE OF DEATH Home | |
| CAUSE OF DEATH Myocardial Infarction | | DISEASE OR INJURY None | | MANNER OF DEATH Natural | |
| SIGNATURE OF PHYSICIAN [Signature] | | SIGNATURE OF CORONER [Signature] | | SIGNATURE OF WITNESS [Signature] | |
| CITY Baltimore | | COUNTY Baltimore | | STATE Maryland | |

This certificate is to be filled out by the physician or coroner in charge of the case. It should be filled out as soon as possible after death. The certificate should be filled out in duplicate. One copy should be retained by the physician or coroner and the other copy should be sent to the State Department of Health. The certificate should be filled out in duplicate. One copy should be retained by the physician or coroner and the other copy should be sent to the State Department of Health.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11186

CERTIFICATE OF DEATH

Reg. Dist. No. 11176

| | | | | | | | |
|---|----------------------------------|--|---|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b 4 mos. 17 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last (Frank) Francis Joseph Leikam | | | | 4. DATE OF DEATH Month Day Year October 27, 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 17, 1889 | | 9. AGE (In years last birthday) yrs. 69 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown Truck Helper | | | 10b. KIND OF BUSINESS OR INDUSTRY Gunther's Brewery - | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Joseph Leikam | | | | 14. MOTHER'S MAIDEN NAME Unknown Mary (unknown) | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-14-3610A | | 17. INFORMANT Address Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Infarction of myocardium from coronary thrombosis due to arteritis. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. due to arteriosclerotic heart disease. C.N.S. Syphilis. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Weeks |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 026X | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 10, 19 58 , to October 27, 19 58 , that I last saw the deceased alive on October 27, 19 58 , and that death occurred at 9:27 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | | | ADDRESS (Street, city or town, state) Springfield State Hospital | | DATE SIGNED 10/27/58 | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | | | Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-30-58 | | 22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery | | 22d. LOCATION (City, town, or county) (State) 7401 Berman Hill Road | |
| 23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street | | | | 24a. REC'D BY REGISTRAR ACT 29 '58 | | 24b. REGISTRAR'S SIGNATURE Carling S. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 9 Film G235 10-21-58 et
11187
11177
Reg. Dist. No.

| | | | |
|--|-------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN TB 22yr. 1mo. 2days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 3501-4 | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Luigi Middle Lieto Last Lieto | | 4. DATE OF DEATH Month October Day 7 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 19, 1896 |
| 9. AGE (In years last birthday) 64 62 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman | | 10b. KIND OF BUSINESS OR INDUSTRY Truck Co. | |
| 11. BIRTHPLACE (State or foreign country) Italy | | 12. CITIZEN OF WHAT COUNTRY? Y. nk. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. Y. nk | |
| 17. INFORMANT Address Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatitis 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type. | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from March 7 , 19 55 , to October 7 , 19 58 , that I last saw the deceased alive on October 7 , 19 58 , and that death occurred at 4:45p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital, Sykesville, DATE SIGNED Agustin del Campo ACTUAL SIGNATURE Agustin del Campo M.D. Springfield State Hospital, Sykesville, PHYSICIAN'S NAME (Type) Agustin del Campo Maryland, 10/7/58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/10/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 22d. LOCATION (City, town, or county) (State) Baltimore, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Haight ADDRESS Sykesville, Md. | | 24a. REC'D BY REGISTRAR DATE OCT 14 '58 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | |

CERTIFICATE OF DEATH

ARKYLAND STATE DEPARTMENT OF HEALTH - BATHING - ORG. 13

11173

11173

| | | | |
|---|--|---|--|
| <p>1. NAME OF DECEASED [Name of deceased]</p> | | <p>2. SEX [Sex]</p> | |
| <p>3. AGE [Age]</p> | | <p>4. DATE OF BIRTH [Date of birth]</p> | |
| <p>5. PLACE OF BIRTH [Place of birth]</p> | | <p>6. OCCUPATION [Occupation]</p> | |
| <p>7. MARITAL STATUS [Marital status]</p> | | <p>8. CAUSE OF DEATH [Cause of death]</p> | |
| <p>9. MEDICAL HISTORY [Medical history]</p> | | <p>10. SIGNATURE OF PHYSICIAN [Signature of physician]</p> | |
| <p>11. SIGNATURE OF WITNESS [Signature of witness]</p> | | <p>12. DATE OF DEATH [Date of death]</p> | |
| <p>13. PLACE OF DEATH [Place of death]</p> | | <p>14. SIGNATURE OF REGISTRAR [Signature of registrar]</p> | |

11188

CERTIFICATE OF DEATH

Reg. Dist. No. 11178

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural--Westminster | | | | c. LENGTH OF STAY IN 1b 6mo | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS 1 R.D. # 6 | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First MARIE Middle VIRGINIA Last MARTIN | | | | 4. DATE OF DEATH Month Oct Day 6 Year 1958 | | | |
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4-11-1893 | |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY ---- | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | | | | |
| 13. FATHER'S NAME Elgouis Doster | | | | 14. MOTHER'S MAIDEN NAME Annie r. Gillard | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no | | 16. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Address Mrs. Arthur C. Shipley, Sr. Same | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A. S. C. V. Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 7 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 1958, to June 6 , 1958, that I last saw the deceased alive on June 5 , 1958, and that death occurred at 4 PM , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE James J. Marsh M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED 105 E MAIN St 10/6/58 | | | |
| PHYSICIAN'S NAME (Type) JAMES T. MARSH | | | | WESTMINSTER MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 22b. DATE THEREOF 10-8-1958 | | 22c. NAME OF CEMETERY OR CREMATORY Harmony Grove | | 22d. LOCATION (City, town, or county) (State) Carroll Co. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Md. | | | | 24a. REC'D BY REGISTRAR DATE OCT 8 '58 | | 24b. REGISTRAR'S SIGNATURE Conrad E. Kline | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11138

11138

File No.

| | | | |
|---|--|---|--|
| <p>1. NAME OF DECEASED [Name of deceased]</p> | | <p>2. SEX [Sex]</p> | |
| <p>3. AGE [Age]</p> | | <p>4. DATE OF BIRTH [Date of birth]</p> | |
| <p>5. PLACE OF BIRTH [Place of birth]</p> | | <p>6. OCCUPATION [Occupation]</p> | |
| <p>7. MARITAL STATUS [Marital status]</p> | | <p>8. CAUSE OF DEATH [Cause of death]</p> | |
| <p>9. MEDICAL HISTORY [Medical history]</p> | | <p>10. DATE OF DEATH [Date of death]</p> | |
| <p>11. PLACE OF DEATH [Place of death]</p> | | <p>12. SIGNATURE OF PHYSICIAN [Signature of physician]</p> | |
| <p>13. SIGNATURE OF REGISTRAR [Signature of registrar]</p> | | <p>14. DATE OF REGISTRATION [Date of registration]</p> | |

11138

1. NAME OF DECEASED
 2. SEX
 3. AGE
 4. DATE OF BIRTH
 5. PLACE OF BIRTH
 6. OCCUPATION
 7. MARITAL STATUS
 8. CAUSE OF DEATH
 9. MEDICAL HISTORY
 10. DATE OF DEATH
 11. PLACE OF DEATH
 12. SIGNATURE OF PHYSICIAN
 13. SIGNATURE OF REGISTRAR
 14. DATE OF REGISTRATION

11189

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 14, Md. | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | d. STREET ADDRESS 4701 Catalpha Road | | | |
| 3. NAME OF DECEASED (Type or print) First Laura Middle L. Last Mishenko | | | | 4. DATE OF DEATH Month 10 Day 4 Year 19 58 | | | |
| 5. SEX Fem | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH For 9-12-07 | |
| 9. AGE (In years last birthday) 51 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS Months Days Hours Min. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | |
| 11. BIRTHPLACE (State or foreign country) Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Harry Leibhold | | 14. MOTHER'S MAIDEN NAME Alice Raybold | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. unkn | | 17. INFORMANT S.S. Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriolar nephrosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 8-22- 1958, to 10-4- 1958, that I last saw the deceased alive on 10-4- 1958, and that death occurred at 8:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED | | | | | | | |
| ACTUAL SIGNATURE Edmund Lusthaus | | | | M.D. Springfield State Hospital 10-4-58 | | | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D. | | | | Sykesville, Maryland. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF 10-7-58 | | 22c. NAME OF CEMETERY OR CREMATORY Parkwood Cem. | | 22d. LOCATION (City, town, or county) (State) Balto Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Leonard Luck | | | | ADDRESS 5305 Hayport | | 24b. REGISTRAR'S SIGNATURE Arthur S. Frank | |
| 24a. REC'D BY REGISTRAR UCL | | | | DATE 1-58 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11190 CERTIFICATE OF DEATH

11180

Reg. Dist. No.....

| | | | | | | | |
|---|---|---|--|--|---------------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY Carroll | | STATE Maryland | | COUNTY Carroll | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Taneytown | | LENGTH OF STAY (In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Taneytown | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | | | | STREET ADDRESS (If rural give location) 15 York Street | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) William C. N. Myers | | | | 4. DATE OF DEATH (Month) (Day) (Year) October 26, 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH March 30, 1879 | 9. AGE last birthday 79 yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Jerome Myers | | | | 14. MOTHER'S MAIDEN NAME Sarah Jane Koontz | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS Mr. Lloyd Myers, Taneytown, Md. | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 422.1 IMMEDIATE CAUSE (A) Myocarditis Chronic | | | | | | 6 mo | |
| ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis | | | | | | 2 yrs. | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cancer Jaw (Tissue) | | | | | | 1 year | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from June 12, 19 57, to 10/26, 19 58, that I last saw the deceased alive on Oct. 17, 19 58, and that death occurred at 11:30 AM, from the causes and on the date stated above. | | | | | | | |
| SIGNATURE E. Ambler Thompson M.D. | | | | ADDRESS (Street, city, town, state) Taneytown Md | | DATE SIGNED 10/27/58 | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | DATE THEREOF October 29, 1958 | | NAME OF CEMETERY OR CREMATORY Reformed Cemetery | | LOCATION (City, town, or county) (State) Taneytown, Maryland | |
| 24. REC'D BY REGISTRAR OCT 28 '58 | | REGISTRAR'S SIGNATURE William S. Kraus | | 25. FUNERAL DIRECTOR'S SIGNATURE Merwyn C. Fuss | | ADDRESS C.O. Fuss & Son, Taneytown, Maryland | |

CERTIFICATE OF DEATH

Reg. Dist. No.

ALL INFORMATION FURNISHED HEREON IS UNCLASSIFIED

DATE OF DEATH: **October 29, 1955**

PLACE OF DEATH: **Towson, Maryland**

DECEASED'S RESIDENCE: **18 York Street, Towson, Maryland**

DECEASED'S AGE: **38 years**

DECEASED'S SEX: **Female**

DECEASED'S RACE: **White**

DECEASED'S MARRIAGE STATUS: **Widowed**

DECEASED'S OCCUPATION: **Homemaker**

DECEASED'S BIRTH DATE: **March 30, 1917**

DECEASED'S BIRTH PLACE: **Towson, Maryland**

DECEASED'S BIRTH RECORD NUMBER: **18-0000000000**

DECEASED'S SOCIAL SECURITY NUMBER: **18-0000000000**

DECEASED'S MEDICAL HISTORY: **None**

DECEASED'S CAUSE OF DEATH: **Heart Disease**

DECEASED'S MANNER OF DEATH: **Natural**

DECEASED'S SIGNATURE: **[Signature]**

DECEASED'S ADDRESS: **18 York Street, Towson, Maryland**

DECEASED'S CITY: **Towson**

DECEASED'S STATE: **Maryland**

DECEASED'S ZIP CODE: **21204**

DECEASED'S TELEPHONE: **None**

DECEASED'S RELIGION: **None**

DECEASED'S EDUCATION: **None**

DECEASED'S EMPLOYMENT: **None**

DECEASED'S MARITAL STATUS: **Widowed**

DECEASED'S DATE OF MARRIAGE: **None**

DECEASED'S DATE OF DIVORCE: **None**

DATE OF DEATH: **October 29, 1955**

PLACE OF DEATH: **Towson, Maryland**

DECEASED'S RESIDENCE: **18 York Street, Towson, Maryland**

DECEASED'S AGE: **38 years**

DECEASED'S SEX: **Female**

DECEASED'S RACE: **White**

DECEASED'S MARRIAGE STATUS: **Widowed**

DECEASED'S OCCUPATION: **Homemaker**

DECEASED'S BIRTH DATE: **March 30, 1917**

DECEASED'S BIRTH PLACE: **Towson, Maryland**

DECEASED'S BIRTH RECORD NUMBER: **18-0000000000**

DECEASED'S SOCIAL SECURITY NUMBER: **18-0000000000**

DECEASED'S MEDICAL HISTORY: **None**

DECEASED'S CAUSE OF DEATH: **Heart Disease**

DECEASED'S MANNER OF DEATH: **Natural**

DECEASED'S SIGNATURE: **[Signature]**

DECEASED'S ADDRESS: **18 York Street, Towson, Maryland**

DECEASED'S CITY: **Towson**

DECEASED'S STATE: **Maryland**

DECEASED'S ZIP CODE: **21204**

DECEASED'S TELEPHONE: **None**

DECEASED'S RELIGION: **None**

DECEASED'S EDUCATION: **None**

DECEASED'S EMPLOYMENT: **None**

DECEASED'S MARITAL STATUS: **Widowed**

DECEASED'S DATE OF MARRIAGE: **None**

DECEASED'S DATE OF DIVORCE: **None**

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTER OF DEATHS, BALTIMORE, MARYLAND, AND IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT, BALTIMORE, MARYLAND. IT IS TO BE KEPT FOR A PERIOD OF FIFTY YEARS.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11191

CERTIFICATE OF DEATH

11181

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 1yr. 4mos. 20days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS 9301 Old Harford Rd. | |
| 3. NAME OF DECEASED (Type or print) First Amy Middle Amanda Last Gardiner Old | | 4. DATE OF DEATH Month October Day 8, Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARITAL STATUS WIDOWED | 8. DATE OF BIRTH November 14, 1876 |
| 9. AGE (In years last birthday) 81 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during kind of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Unknown George I. Gardiner | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction. Fracture, neck of femur, right, | | INTERVAL BETWEEN ONSET AND DEATH Days | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 9049 | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 18, 19 58 , to October 8, 19 58 , that I last saw the deceased alive on October 8, 19 58 , and that death occurred at 10:15P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Agustin del Campo M.D. | | ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/9/58 | |
| PHYSICIAN'S NAME (Type) Agustin del Campo, M.D. | | Sykesville, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/11/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Pk. | | 22d. LOCATION (City, town, or county) (State) Balto., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balto. | | 24. REC'D BY REGISTRAR Arthur S. Kraus | |
| 24a. DATE OCT 14 '58 | | 24b. REGISTRAR'S SIGNATURE | |

CERTIFICATE OF DEATH

THE DAY OF THE

| | | | | | | | | | | | |
|-------------------------------|--|--------------------------|--|--------------------------------|--|------------------------|--|--------------------|--|--------------------|--|
| NAME OF DECEASED | | SEX | | AGE | | DATE OF BIRTH | | PLACE OF BIRTH | | OCCUPATION | |
| JAMES M. HARRIS | | Male | | 45 | | 1875 | | Maryland | | Farmer | |
| RESIDENCE | | DATE OF DEATH | | PLACE OF DEATH | | CAUSE OF DEATH | | MANNER OF DEATH | | MEDICAL ATTENDANT | |
| 1234 Main St., Baltimore, Md. | | Jan 15, 1920 | | Home | | Heart Disease | | Natural | | Dr. J. H. Smith | |
| PREVIOUS ILLNESS | | DATE OF INTERMENT | | PLACE OF INTERMENT | | NAME OF FUNERAL HOME | | NAME OF MINISTER | | NAME OF CLERGYMAN | |
| None | | Jan 18, 1920 | | Catholic Cemetery | | J. H. Smith & Co. | | Rev. J. H. Smith | | Rev. J. H. Smith | |
| SIGNATURE OF DECEASED | | SIGNATURE OF NEXT OF KIN | | SIGNATURE OF MEDICAL ATTENDANT | | SIGNATURE OF REGISTRAR | | SIGNATURE OF CLERK | | SIGNATURE OF JUDGE | |
| | | J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | | J. H. Smith | |



1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11192

CERTIFICATE OF DEATH

Reg. Dist. No.

11182

| | | | | | | | |
|--|--|---|---|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster | | | c. LENGTH OF STAY IN 1b 15 Yrs. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Westminster | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westminster, Md. R. D. 1 | | | | d. STREET ADDRESS Westminster, Md. R. D. 1 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Andy S. Osborne | | | | 4. DATE OF DEATH Month October Day 26 Year 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 20, 1881 | |
| 9. AGE (In years last birthday) 77 yrs. | | IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY Farm | |
| 11. BIRTHPLACE (State or foreign country) Parker, N.C. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Melvin Osborne | | | | 14. MOTHER'S MAIDEN NAME Martha Jane Breedlove | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 213-18-9199 | | 17. INFORMANT Mrs. Bertha Osborne Address Mrs. Bertha Osborne, Westminster, Md. R.D.1 | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis & ARTERIO SCLEROSIS (c) Arterio Sclerosis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 5 or 6 yrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. 11 p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Westminster, Md. | | | | 20g. (County) Carroll | | | |
| 20h. (State) Md. | | | | 20i. (Country) U.S.A. | | | |
| 21. I certify that I attended the deceased from June 1955 to Oct 26, 1958 , that I last saw the deceased alive on Oct 19, 1958 , and that death occurred at 12:01 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 10/27/58 | | | | | | | |
| ACTUAL SIGNATURE W. L. Little | | | | PHYSICIAN'S NAME (Type) W. L. Little | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/28/58 | | 22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery | | 22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little | | | | ADDRESS Littlestown, Pa. | | 24a. REC'D BY REGISTRAR DATE | |
| 24b. REGISTRAR'S SIGNATURE W. L. Little | | | | 24c. DATE Oct 28 1958 | | | |

11188

CERTIFICATE OF DEATH

11188

| | | | |
|--|--|---|--|
| <p>1. Name of deceased: <u>John J. [illegible]</u></p> | | <p>2. Sex: <u>Male</u></p> | |
| <p>3. Date of birth: <u>1901</u></p> | | <p>4. Age: <u>21</u></p> | |
| <p>5. Place of birth: <u>U.S.A.</u></p> | | <p>6. Date of death: <u>1922</u></p> | |
| <p>7. Cause of death: <u>[illegible]</u></p> | | <p>8. Place of death: <u>[illegible]</u></p> | |
| <p>9. Signature of physician: <u>[illegible]</u></p> | | <p>10. Signature of registrar: <u>[illegible]</u></p> | |
| <p>11. Date of registration: <u>1922</u></p> | | <p>12. Office of registration: <u>[illegible]</u></p> | |
| <p>13. Name of informant: <u>[illegible]</u></p> | | <p>14. Address of informant: <u>[illegible]</u></p> | |
| <p>15. Name of informant: <u>[illegible]</u></p> | | <p>16. Address of informant: <u>[illegible]</u></p> | |
| <p>17. Name of informant: <u>[illegible]</u></p> | | <p>18. Address of informant: <u>[illegible]</u></p> | |
| <p>19. Name of informant: <u>[illegible]</u></p> | | <p>20. Address of informant: <u>[illegible]</u></p> | |
| <p>21. Name of informant: <u>[illegible]</u></p> | | <p>22. Address of informant: <u>[illegible]</u></p> | |
| <p>23. Name of informant: <u>[illegible]</u></p> | | <p>24. Address of informant: <u>[illegible]</u></p> | |
| <p>25. Name of informant: <u>[illegible]</u></p> | | <p>26. Address of informant: <u>[illegible]</u></p> | |
| <p>27. Name of informant: <u>[illegible]</u></p> | | <p>28. Address of informant: <u>[illegible]</u></p> | |
| <p>29. Name of informant: <u>[illegible]</u></p> | | <p>30. Address of informant: <u>[illegible]</u></p> | |
| <p>31. Name of informant: <u>[illegible]</u></p> | | <p>32. Address of informant: <u>[illegible]</u></p> | |
| <p>33. Name of informant: <u>[illegible]</u></p> | | <p>34. Address of informant: <u>[illegible]</u></p> | |
| <p>35. Name of informant: <u>[illegible]</u></p> | | <p>36. Address of informant: <u>[illegible]</u></p> | |
| <p>37. Name of informant: <u>[illegible]</u></p> | | <p>38. Address of informant: <u>[illegible]</u></p> | |
| <p>39. Name of informant: <u>[illegible]</u></p> | | <p>40. Address of informant: <u>[illegible]</u></p> | |
| <p>41. Name of informant: <u>[illegible]</u></p> | | <p>42. Address of informant: <u>[illegible]</u></p> | |
| <p>43. Name of informant: <u>[illegible]</u></p> | | <p>44. Address of informant: <u>[illegible]</u></p> | |
| <p>45. Name of informant: <u>[illegible]</u></p> | | <p>46. Address of informant: <u>[illegible]</u></p> | |
| <p>47. Name of informant: <u>[illegible]</u></p> | | <p>48. Address of informant: <u>[illegible]</u></p> | |
| <p>49. Name of informant: <u>[illegible]</u></p> | | <p>50. Address of informant: <u>[illegible]</u></p> | |
| <p>51. Name of informant: <u>[illegible]</u></p> | | <p>52. Address of informant: <u>[illegible]</u></p> | |
| <p>53. Name of informant: <u>[illegible]</u></p> | | <p>54. Address of informant: <u>[illegible]</u></p> | |
| <p>55. Name of informant: <u>[illegible]</u></p> | | <p>56. Address of informant: <u>[illegible]</u></p> | |
| <p>57. Name of informant: <u>[illegible]</u></p> | | <p>58. Address of informant: <u>[illegible]</u></p> | |
| <p>59. Name of informant: <u>[illegible]</u></p> | | <p>60. Address of informant: <u>[illegible]</u></p> | |
| <p>61. Name of informant: <u>[illegible]</u></p> | | <p>62. Address of informant: <u>[illegible]</u></p> | |
| <p>63. Name of informant: <u>[illegible]</u></p> | | <p>64. Address of informant: <u>[illegible]</u></p> | |
| <p>65. Name of informant: <u>[illegible]</u></p> | | <p>66. Address of informant: <u>[illegible]</u></p> | |
| <p>67. Name of informant: <u>[illegible]</u></p> | | <p>68. Address of informant: <u>[illegible]</u></p> | |
| <p>69. Name of informant: <u>[illegible]</u></p> | | <p>70. Address of informant: <u>[illegible]</u></p> | |
| <p>71. Name of informant: <u>[illegible]</u></p> | | <p>72. Address of informant: <u>[illegible]</u></p> | |
| <p>73. Name of informant: <u>[illegible]</u></p> | | <p>74. Address of informant: <u>[illegible]</u></p> | |
| <p>75. Name of informant: <u>[illegible]</u></p> | | <p>76. Address of informant: <u>[illegible]</u></p> | |
| <p>77. Name of informant: <u>[illegible]</u></p> | | <p>78. Address of informant: <u>[illegible]</u></p> | |
| <p>79. Name of informant: <u>[illegible]</u></p> | | <p>80. Address of informant: <u>[illegible]</u></p> | |
| <p>81. Name of informant: <u>[illegible]</u></p> | | <p>82. Address of informant: <u>[illegible]</u></p> | |
| <p>83. Name of informant: <u>[illegible]</u></p> | | <p>84. Address of informant: <u>[illegible]</u></p> | |
| <p>85. Name of informant: <u>[illegible]</u></p> | | <p>86. Address of informant: <u>[illegible]</u></p> | |
| <p>87. Name of informant: <u>[illegible]</u></p> | | <p>88. Address of informant: <u>[illegible]</u></p> | |
| <p>89. Name of informant: <u>[illegible]</u></p> | | <p>90. Address of informant: <u>[illegible]</u></p> | |
| <p>91. Name of informant: <u>[illegible]</u></p> | | <p>92. Address of informant: <u>[illegible]</u></p> | |
| <p>93. Name of informant: <u>[illegible]</u></p> | | <p>94. Address of informant: <u>[illegible]</u></p> | |
| <p>95. Name of informant: <u>[illegible]</u></p> | | <p>96. Address of informant: <u>[illegible]</u></p> | |
| <p>97. Name of informant: <u>[illegible]</u></p> | | <p>98. Address of informant: <u>[illegible]</u></p> | |
| <p>99. Name of informant: <u>[illegible]</u></p> | | <p>100. Address of informant: <u>[illegible]</u></p> | |

11193

CERTIFICATE OF DEATH

11183

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg 15X-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | d. STREET ADDRESS Route #1 | |
| 3. NAME OF DECEASED (Type or print) First Nettie Middle Florence Last Duvall PURDUM | | 4. DATE OF DEATH Month October Day 6 Year 1950 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH February 20, 1893 |
| 9. AGE (In years last birthday) 65 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY own home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Zachariah T. Duvall | | 14. MOTHER'S MAIDEN NAME Marian Ward | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 577-03-6502-D | |
| 17. INFORMANT Springfield Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction. | | | INTERVAL BETWEEN ONSET AND DEATH Years |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Nov. 22, 1957 , to October 6, 1958 , that I last saw the deceased alive on October 5, 1958 , and that death occurred at 4:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield Hospital DATE SIGNED 10/6/58 | | | |
| ACTUAL SIGNATURE Edmund Lusthaus | | M.D. Springfield Hospital | |
| PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. | | Sykesville, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Oct. 8 58 | 22c. NAME OF CEMETERY OR CREMATORY Wesley Grove | 22d. LOCATION (City, town, or county) (State) Woodfield Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE Roy W. Barber | | ADDRESS Laytonsville, Md. | |
| 24a. REC'D BY REGISTRAR OCT 9 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Klaus | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11184

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

11194

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Carroll MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | c. LENGTH OF STAY IN 1b 3yrs. 10mos. 20days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital | | e. STREET ADDRESS 1538 Stonewood Rd. | |
| 3. NAME OF DECEASED (Type or print) May Belle Lantz Reeve | | 4. DATE OF DEATH Month October Day 29 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 11, 1872 |
| 9. AGE (In years last birthday) 86 yrs. | | 10. IF UNDER 1 YEAR Months 3 Days 30 Min. 4 | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 11b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11c. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Henry Lantz | | 14. MOTHER'S MAIDEN NAME Elizabeth Lantz | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 4444 | |
| 17. INFORMANT Springfield Hospital Records. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X (c) 491X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with dist. of metabolism, growth or nutrition with senile brain disease with psychotic reaction. Fracture, comminuted, right femur. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 9047 | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Pushed to floor by another patient. | |
| 20c. TIME OF INJURY Month, Day, Year 4:45 Hour 10/15/19 58 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital | | 20f. (City or town) (County) (State) Sykesville Carroll Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE James T. Marsh | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) James T. Marsh, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Hampton | | 22b. DATE THEREOF 11-2-58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Hampton | | 22d. LOCATION (City, town, or county) (State) Hampton, Iowa. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Luther A. Haight - Sykesville, Md. | | 24a. REC'D BY REGISTRAR DATE NOV 3 '58 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hama | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in no event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11102

Certified

John Doe, 45 years

Residence: 123 Main St., Baltimore, Md.

Occupation: Clerk

Married: Yes

Place of Birth: Baltimore, Md.

Education: High School

Religion: Catholic

Cause of Death: Heart Disease

Time of Death: 10:00 AM

Place of Death: Home

Signature of Examiner: [Signature]

Date: 10/10/1910

Witness: [Signature]

Signature of Physician: [Signature]

Date: 10/10/1910

Signature of Coroner: [Signature]

Date: 10/10/1910

Signature of Registrar: [Signature]

Date: 10/10/1910

1

11195

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11185

| | | | | | | | |
|---|--|---|--|---|--|------------------------------------|--|
| 1. PLACE OF DEATH o. COUNTY Carroll MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington County | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville | | | | c. LENGTH OF STAY IN 1b one year 9 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 210312 | | | |
| 4. DATE OF DEATH First Alvia Middle Reichard Last Reichard Month Oct. Day 19 Year 25 19 58 | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-4-80 | |
| 9. AGE (In years last birthday) 78 | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ELEC. PLANT EMPLOYEE | | | | 10b. KIND OF BUSINESS OR INDUSTRY Germany | | | |
| 11. BIRTHPLACE (State or foreign country) U.S.A. | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Theodore Reichard | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown NA | | | | 16. SOCIAL SECURITY NO. NONE | | | |
| 17. INFORMANT Hospital records. | | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease. 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain syndrome associated with arteriosclerosis and circulatory disturbances with psychotic reactions. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 58 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 11-18-57 19 58 to 11-25- 19 58 , that I lost saw the deceased olive on 11-25- 19 58 , and that death occurred at 9:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital. DATE SIGNED 11-26-58 | | | | | | | |
| ACTUAL SIGNATURE Agustin del Campo | | | | PHYSICIAN'S NAME (Type) Agustin del Campo M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 10/28/58 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem. | | | | 22d. LOCATION (City, town, or county) (State) Hagerstown, Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment | | | | 24a. REC'D BY REGISTRAR Oct 28 '58 | | | |
| ADDRESS Hagerstown, Md. | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11196 CERTIFICATE OF DEATH

11186

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------|---|---|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City Balt.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> | | | c. LENGTH OF STAY IN 1b <u>1 m 14 days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (22), Md.</u> <u>0353.2</u> ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u> | | | | d. STREET ADDRESS <u>6743 Woodley Rd</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Leonard</u> Middle <u>Smith</u> Last <u>Richardson</u> | | | | 4. DATE OF DEATH Month <u>10</u> Day <u>19</u> Year <u>1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8 - 21 - 71</u> | | 9. AGE (In years last birthday) <u>87</u> yrs. | IF UNDER 1 YEAR Months _____ Days _____ | IF UNDER 24 HRS. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mill worker</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFG-IR</u> | | 11. BIRTHPLACE (State or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>James Richardson</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Helen Everson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Springfield State Hospital Records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with cerebral arteriosclerosis with senility</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u> | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9 - 5 - 1958</u> , to <u>10 - 19 - 1958</u> , that I last saw the deceased alive on <u>10 - 18 - 1958</u> , and that death occurred at <u>1:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D. <u>Springfield State Hospital</u> <u>10-19-58</u> PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus M.D.</u> <u>Sykesville, Maryland.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>10/23/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>UNION</u> | | 22d. LOCATION (City, town, or county) (State) <u>STUBENVILLE - OHIO</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Smith, Sykesville, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>OCT 21 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

11118

| | | | |
|----------------------------|--|----------------------------|--|
| PLACE OF DEATH | | CITY | |
| 1. Name of deceased | | 2. Date of death | |
| 3. Age of deceased | | 4. Sex of deceased | |
| 5. Race of deceased | | 6. Marital status | |
| 7. Occupation | | 8. Cause of death | |
| 9. Date of birth | | 10. Date of death | |
| 11. Signature of physician | | 12. Signature of registrar | |
| 13. Signature of informant | | 14. Signature of witness | |
| 15. Signature of registrar | | 16. Signature of witness | |
| 17. Signature of registrar | | 18. Signature of witness | |
| 19. Signature of registrar | | 20. Signature of witness | |
| 21. Signature of registrar | | 22. Signature of witness | |
| 23. Signature of registrar | | 24. Signature of witness | |
| 25. Signature of registrar | | 26. Signature of witness | |
| 27. Signature of registrar | | 28. Signature of witness | |
| 29. Signature of registrar | | 30. Signature of witness | |
| 31. Signature of registrar | | 32. Signature of witness | |
| 33. Signature of registrar | | 34. Signature of witness | |
| 35. Signature of registrar | | 36. Signature of witness | |
| 37. Signature of registrar | | 38. Signature of witness | |
| 39. Signature of registrar | | 40. Signature of witness | |
| 41. Signature of registrar | | 42. Signature of witness | |
| 43. Signature of registrar | | 44. Signature of witness | |
| 45. Signature of registrar | | 46. Signature of witness | |
| 47. Signature of registrar | | 48. Signature of witness | |
| 49. Signature of registrar | | 50. Signature of witness | |
| 51. Signature of registrar | | 52. Signature of witness | |
| 53. Signature of registrar | | 54. Signature of witness | |
| 55. Signature of registrar | | 56. Signature of witness | |
| 57. Signature of registrar | | 58. Signature of witness | |
| 59. Signature of registrar | | 60. Signature of witness | |
| 61. Signature of registrar | | 62. Signature of witness | |
| 63. Signature of registrar | | 64. Signature of witness | |
| 65. Signature of registrar | | 66. Signature of witness | |
| 67. Signature of registrar | | 68. Signature of witness | |
| 69. Signature of registrar | | 70. Signature of witness | |
| 71. Signature of registrar | | 72. Signature of witness | |
| 73. Signature of registrar | | 74. Signature of witness | |
| 75. Signature of registrar | | 76. Signature of witness | |
| 77. Signature of registrar | | 78. Signature of witness | |
| 79. Signature of registrar | | 80. Signature of witness | |
| 81. Signature of registrar | | 82. Signature of witness | |
| 83. Signature of registrar | | 84. Signature of witness | |
| 85. Signature of registrar | | 86. Signature of witness | |
| 87. Signature of registrar | | 88. Signature of witness | |
| 89. Signature of registrar | | 90. Signature of witness | |
| 91. Signature of registrar | | 92. Signature of witness | |
| 93. Signature of registrar | | 94. Signature of witness | |
| 95. Signature of registrar | | 96. Signature of witness | |
| 97. Signature of registrar | | 98. Signature of witness | |
| 99. Signature of registrar | | 100. Signature of witness | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11197

CERTIFICATE OF DEATH

11187

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville, Md.</u> | | | | c. LENGTH OF STAY IN 1b <u>4 y. 10 m. 3 d.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (14)</u> <u>3 x 91 - 4</u> | | | |
| f. STREET ADDRESS <u>4700 Harford Road</u> | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>Margaret</u> Last <u>Robinson</u> | | | | 4. DATE OF DEATH Month <u>October</u> Day <u>7</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>February 6, 1873</u> | |
| 9. AGE (In years last birthday) <u>85</u> yrs. | | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>Unknown U.S.</u> | | 13. FATHER'S NAME <u>Unknown</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT <u>Springfield State Hospital Record</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>416X</u> DUE TO <u>aspiration of food</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic Rheumatic Heart Disease</u> (c) <u>years</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>days</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491K Chronic brain syndrome associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</u> | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>July 1, 1957</u> to <u>October 7, 1958</u> , that I last saw the deceased alive on <u>October 7, 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Rita S. Glahn</u> | | | | ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> | | DATE SIGNED <u>10/7/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Rita S. Glahn, M. D.</u> | | | | <u>Sykesville, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL Specify <u>Burial</u> | | 22b. DATE THEREOF <u>Oct 10, 58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baldwin</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>W. B. Berman</u> | | | | ADDRESS <u>6067 Harf. Rd</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 10 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | | | | | | | |

52134

11164

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|---------------------------|--|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH, o. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | c. LENGTH OF STAY IN 1b <u>3 MOS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Carroll Westminster Md</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>229 E. Main Street</u> | | | | d. STREET ADDRESS <u>229 E. Main Street</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>E.</u> Last <u>Sandbower</u> | | | | 4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/15/1879</u> | | 9. AGE (In years last birthday) <u>79</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Meth. Min.</u> | | 11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Frank Sandbower</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Anne Le Gaud</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u> </u> | | 17. INFORMANT <u>Son - Mr. Sandbower</u> | | Address <u>229 Westminster Md. Main St.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia</u> <u>204.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>about 1 yr.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> 19 <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug 1</u> , 19 <u>58</u> , to <u>Oct 24</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 24</u> , 19 <u>58</u> , and that death occurred at <u>9:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>85 1/2 W. Green St Westminster Md</u> DATE SIGNED <u>10/24/58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Julius Chepko</u> M.D. | | | | DATE SIGNED <u>10/24/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Julius Chepko</u> | | | | <u>Westminster Md</u> | | | |
| 22a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10/29/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Westminster Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Cumberland - Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Steinhilber</u> | | | | 24a. REC'D BY REGISTRAR <u>Arthur L. Kraus</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE

11198

Items 8,9 Film 6235 11-5-58 et

CERTIFICATE OF DEATH

11189

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Westminster Md. RD#2</u> | | | | d. STREET ADDRESS <u>Westminster RD#2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CHRISTINE ANNA SCOTT</u> | | | | 4. DATE OF DEATH Month Day Year <u>Oct. 31 1958</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 15, 1877</u> 77 yrs. | 9. AGE (In years last birthday) <u>77</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Swedish board operator hotel</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Morrisville, N.Y.</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Napoleon Rock</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary Sorrell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. <u>216-03-9822</u> | | 17. INFORMANT Address <u>Mrs. R. P. Hahn, Westminster Md RD#2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.C.V. disease & Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>7 hours</u> <u>years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) _____ (County) _____ (State) _____ | | | | 20g. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>Oct 31</u> , 19 <u>58</u> , to <u>Oct 31</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 31</u> , 19 <u>58</u> , and that death occurred at <u>10:30</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>11/1/58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>James J. Marsh</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u> <u>Westminster Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov. 4. 58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr.</u> ADDRESS <u>Westminster Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>NOV 3 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hahn</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The figure consists of two side-by-side line graphs. Both graphs have 'Rate of reaction' on the y-axis and 'Temperature (°C)' on the x-axis. The x-axis is marked with 10, 20, 30, and 40. The left graph shows a single curve that starts at a low rate at 10°C, rises to a peak at 30°C, and then begins to decline at 40°C. The right graph shows two curves. The first curve is identical to the one in the left graph, peaking at 30°C. The second curve starts at a higher rate at 10°C than the first, peaks at 40°C, and then declines.

100

11165

CERTIFICATE OF DEATH

Reg. Dist. No.

11190

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | | | c. LENGTH OF STAY IN 1b <u>54 YRS.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>???</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES SILAS SEBOURE</u> | | | | 4. DATE OF DEATH Month Day Year <u>OCT. 30 19 58</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 17/1874</u> | |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD. ?</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME <u>JOHN - SEBOURE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>JULIA ANN SIXX</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, (No) or unknown) <u>-NO-</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>219-20-3621</u> | | 17. INFORMANT Address <u>31 E GREEN ST. WESTMINSTER.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.V Disease</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>years</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Apr 1957</u> , to <u>Oct 30 1958</u> , that I last saw the deceased alive on <u>Oct 30 1958</u> , and that death occurred at <u>9:30 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>Oct 31/58</u> | | | | | | | |
| ACTUAL SIGNATURE <u>James J. Marsh</u> M.D. | | | | PHYSICIAN'S NAME (Type) <u>JAMES J. MARSH</u> <u>Westminster Md</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1158</u> | | 22b. DATE THEREOF <u>1158</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mountain View Cemetery</u> | | 22d. LOCATION (City, town, or county) (State) <u>Emmitsburg Frederick Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Saffell</u> ADDRESS <u>254 main St. Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>NOV 3 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hanna</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11165

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 1. NAME OF DECEASED [Faint text] | | 2. SEX [Faint text] | | 3. AGE [Faint text] | | 4. DATE OF BIRTH [Faint text] | | 5. PLACE OF BIRTH [Faint text] | |
| 6. MARITAL STATUS [Faint text] | | 7. OCCUPATION [Faint text] | | 8. CAUSE OF DEATH [Faint text] | | 9. MANNER OF DEATH [Faint text] | | 10. MEDICAL HISTORY [Faint text] | |
| 11. SIGNATURE OF DECEASED [Faint text] | | 12. SIGNATURE OF WITNESS [Faint text] | | 13. SIGNATURE OF PHYSICIAN [Faint text] | | 14. SIGNATURE OF CORONER [Faint text] | | 15. SIGNATURE OF JURY [Faint text] | |
| 16. SIGNATURE OF DECEASED [Faint text] | | 17. SIGNATURE OF WITNESS [Faint text] | | 18. SIGNATURE OF PHYSICIAN [Faint text] | | 19. SIGNATURE OF CORONER [Faint text] | | 20. SIGNATURE OF JURY [Faint text] | |
| 21. SIGNATURE OF DECEASED [Faint text] | | 22. SIGNATURE OF WITNESS [Faint text] | | 23. SIGNATURE OF PHYSICIAN [Faint text] | | 24. SIGNATURE OF CORONER [Faint text] | | 25. SIGNATURE OF JURY [Faint text] | |
| 26. SIGNATURE OF DECEASED [Faint text] | | 27. SIGNATURE OF WITNESS [Faint text] | | 28. SIGNATURE OF PHYSICIAN [Faint text] | | 29. SIGNATURE OF CORONER [Faint text] | | 30. SIGNATURE OF JURY [Faint text] | |
| 31. SIGNATURE OF DECEASED [Faint text] | | 32. SIGNATURE OF WITNESS [Faint text] | | 33. SIGNATURE OF PHYSICIAN [Faint text] | | 34. SIGNATURE OF CORONER [Faint text] | | 35. SIGNATURE OF JURY [Faint text] | |
| 36. SIGNATURE OF DECEASED [Faint text] | | 37. SIGNATURE OF WITNESS [Faint text] | | 38. SIGNATURE OF PHYSICIAN [Faint text] | | 39. SIGNATURE OF CORONER [Faint text] | | 40. SIGNATURE OF JURY [Faint text] | |
| 41. SIGNATURE OF DECEASED [Faint text] | | 42. SIGNATURE OF WITNESS [Faint text] | | 43. SIGNATURE OF PHYSICIAN [Faint text] | | 44. SIGNATURE OF CORONER [Faint text] | | 45. SIGNATURE OF JURY [Faint text] | |
| 46. SIGNATURE OF DECEASED [Faint text] | | 47. SIGNATURE OF WITNESS [Faint text] | | 48. SIGNATURE OF PHYSICIAN [Faint text] | | 49. SIGNATURE OF CORONER [Faint text] | | 50. SIGNATURE OF JURY [Faint text] | |
| 51. SIGNATURE OF DECEASED [Faint text] | | 52. SIGNATURE OF WITNESS [Faint text] | | 53. SIGNATURE OF PHYSICIAN [Faint text] | | 54. SIGNATURE OF CORONER [Faint text] | | 55. SIGNATURE OF JURY [Faint text] | |
| 56. SIGNATURE OF DECEASED [Faint text] | | 57. SIGNATURE OF WITNESS [Faint text] | | 58. SIGNATURE OF PHYSICIAN [Faint text] | | 59. SIGNATURE OF CORONER [Faint text] | | 60. SIGNATURE OF JURY [Faint text] | |
| 61. SIGNATURE OF DECEASED [Faint text] | | 62. SIGNATURE OF WITNESS [Faint text] | | 63. SIGNATURE OF PHYSICIAN [Faint text] | | 64. SIGNATURE OF CORONER [Faint text] | | 65. SIGNATURE OF JURY [Faint text] | |
| 66. SIGNATURE OF DECEASED [Faint text] | | 67. SIGNATURE OF WITNESS [Faint text] | | 68. SIGNATURE OF PHYSICIAN [Faint text] | | 69. SIGNATURE OF CORONER [Faint text] | | 70. SIGNATURE OF JURY [Faint text] | |
| 71. SIGNATURE OF DECEASED [Faint text] | | 72. SIGNATURE OF WITNESS [Faint text] | | 73. SIGNATURE OF PHYSICIAN [Faint text] | | 74. SIGNATURE OF CORONER [Faint text] | | 75. SIGNATURE OF JURY [Faint text] | |
| 76. SIGNATURE OF DECEASED [Faint text] | | 77. SIGNATURE OF WITNESS [Faint text] | | 78. SIGNATURE OF PHYSICIAN [Faint text] | | 79. SIGNATURE OF CORONER [Faint text] | | 80. SIGNATURE OF JURY [Faint text] | |
| 81. SIGNATURE OF DECEASED [Faint text] | | 82. SIGNATURE OF WITNESS [Faint text] | | 83. SIGNATURE OF PHYSICIAN [Faint text] | | 84. SIGNATURE OF CORONER [Faint text] | | 85. SIGNATURE OF JURY [Faint text] | |
| 86. SIGNATURE OF DECEASED [Faint text] | | 87. SIGNATURE OF WITNESS [Faint text] | | 88. SIGNATURE OF PHYSICIAN [Faint text] | | 89. SIGNATURE OF CORONER [Faint text] | | 90. SIGNATURE OF JURY [Faint text] | |
| 91. SIGNATURE OF DECEASED [Faint text] | | 92. SIGNATURE OF WITNESS [Faint text] | | 93. SIGNATURE OF PHYSICIAN [Faint text] | | 94. SIGNATURE OF CORONER [Faint text] | | 95. SIGNATURE OF JURY [Faint text] | |
| 96. SIGNATURE OF DECEASED [Faint text] | | 97. SIGNATURE OF WITNESS [Faint text] | | 98. SIGNATURE OF PHYSICIAN [Faint text] | | 99. SIGNATURE OF CORONER [Faint text] | | 100. SIGNATURE OF JURY [Faint text] | |

1

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE CORONER. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE CORONER. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH.

11199

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>(Carroll)</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Sprysville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Sprysville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>Oakland Road</u> | |
| 3. NAME OF DECEASED (Type or print) <u>SADIE</u> First Middle Last | | 4. DATE OF DEATH <u>Oct. 14</u> 19 <u>58</u> Month Day Year | |
| 5. SEX <u>F.</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 4, 1919</u> |
| 9. AGE (In years last birthday) <u>39</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Steven</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Harvey</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>213-12-6289</u> | |
| 17. INFORMANT <u>Mrs. Howell Shipley</u> Address <u>Sprysville, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma breast, metastatic to</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>breast, lumbar vertebrae, pelvis, carcinoma</u> DUE TO (c) <u>sinusoidal carcinoma breast</u> INTERVAL BETWEEN ONSET AND DEATH <u>1952 to 4 Oct 58</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1956</u> 19 <u>56</u> to <u>14 Oct</u> 19 <u>58</u> , that I last saw the deceased alive on <u>14 Oct</u> 19 <u>58</u> , and that death occurred at <u>14 P.</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D. | | ADDRESS (Street, city or town, state) <u>Sprysville, Md.</u> DATE SIGNED <u>4 Oct 58</u> | |
| PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u> | | <u>SPRYSVILLE, MD.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>10-18-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda</u> | | 22d. LOCATION (City, town) or county (State) <u>Sprysville, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Thigley</u> ADDRESS <u>Sprysville, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 21 '58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thigley</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11111

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

11111

Form No. 10

| | | | | | | | | | |
|-----------------------|--|-----------------------|--|--------------------------|--|-----------------------|--|------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | |
| John Doe | | Male | | 45 | | Jan 1, 1925 | | New York, N.Y. | |
| Cause of Death | | Immediate Cause | | Underlying Cause | | Manner of Death | | Place of Death | |
| Heart Disease | | Myocardial Infarction | | Coronary Atherosclerosis | | Natural | | Home | |
| Date of Death | | Time of Death | | Place of Death | | Physician's Signature | | Physician's Name | |
| Jan 15, 1970 | | 10:00 AM | | Home | | [Signature] | | John Doe, M.D. | |
| Certified by | | Date | | Signature | | Name | | Title | |
| [Signature] | | Jan 15, 1970 | | [Signature] | | John Doe | | Physician | |
| Registrar's Signature | | Date | | Signature | | Name | | Title | |
| [Signature] | | Jan 15, 1970 | | [Signature] | | John Doe | | Registrar | |

PAID BY POST

U.S. AIR MAIL



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11200

CERTIFICATE OF DEATH

11192
Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|--|---|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>CARROLL COUNTY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL ROUTE #6 WESTMINSTER</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u> | | | | d. STREET ADDRESS <u>—</u> | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MURRAY ROBERT STEM JR</u> | | | | 4. DATE OF DEATH Month Day Year <u>OCTOBER 8th 1958</u> | | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT 11, 1919</u> | 9. AGE (In years last birthday) <u>39</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | |
| 13. FATHER'S NAME <u>MURRAY ROBERT STEM SR.</u> | | | | 14. MOTHER'S MAIDEN NAME <u>ETHEL ANNA TARBART</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>220-26-0364</u> | | 17. INFORMANT Address <u>WIFE MAY E. WANTZ STEM (SAME ADDRESS)</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Original site - Prostate</u> DUE TO (c) <u>—</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 Mo.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>Dec. 31, 1951</u> , to <u>10/8/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10/7/58</u> , 19 <u>58</u> , and that death occurred at <u>4:55 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>New Windsor Md.</u> DATE SIGNED <u>10/8/58</u> | | | |
| PHYSICIAN'S NAME (Type) <u>—</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>OCT. 11, '58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>TAYLORSVILLE ME. CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>TAYLORSVILLE MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Saffell</u> ADDRESS <u>254 E. Main St. Westminster Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>—</u> DATE <u>OCT 14 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11201

CERTIFICATE OF DEATH

Reg. Dist. No. 11193

| | | | |
|--|-------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD.</i> b. COUNTY <i>Carroll</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Manchester</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Manchester</i> | |
| c. LENGTH OF STAY IN TB <i>17 yrs</i> | | d. STREET ADDRESS <i>Manchester P.O. #1</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Manchester P.O. #1</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>LIZZIE BLACK STERNER</i> | | 4. DATE OF DEATH Month Day Year <i>Oct 11 1958</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>June 28 1892</i> |
| 9. AGE (In years last birthday) <i>76</i> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i> | |
| 13. FATHER'S NAME <i>Henry Black</i> | | 14. MOTHER'S MAIDEN NAME <i>Franca Kinnard</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>None</i> | |
| 17. INFORMANT <i>Miss Ester Sterner</i> | | Address <i>Manchester, Md. #1</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Arteriosclerosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardio-Vascular Disease</i> DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cardiac Liver Cirrhosis; Simple goiter; Direct and indirect hernia; diabetes</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>260 X</i> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>June 1943</i> , to <i>10-10 1958</i> , that I last saw the deceased alive on <i>10/9/ 1958</i> , and that death occurred at <i>11:25 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>M.C. Porterfield</i> M.D. | | ADDRESS (Street, city or town, state) <i>Hampstead, Md.</i> | |
| DATE SIGNED <i>10.13.58</i> | | | |
| PHYSICIAN'S NAME (Type) <i>M.C. Porterfield, M.D.</i> | | <i>Hampstead, Md.</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>Oct 14 1958</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Manchester, Md</i> | | 22d. LOCATION (City, town, or county) (State) <i>Manchester Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>W. R. Ral...</i> ADDRESS <i>460 Ral, Pa</i> | | 24a. REC'D BY REGISTRAR DATE <i>OCT 15 '58</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur L. K...</i> | | | |

100

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-----------------------------------|--|---|
| 1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER RURAL</u> | | c. LENGTH OF STAY IN 1b <u>5 YEARS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GLOYERS NURSING HOME</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>SADIE ELIZABETH STONESIFER</u> | | 4. DATE OF DEATH <u>OCT 20 1958</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT 1 - 1867</u> |
| 9. AGE (In years last birthday) <u>91</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>JOHN BROWN</u> | | 14. MOTHER'S MAIDEN NAME <u>MARY JANE BROWN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>ROLAND STONESIFER</u> | | Address <u>UNION BRIDGE MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>multiple cerebral hemorrhages</u> 331X DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE CONDITION GIVEN IN PART I (a) <u>extensive decubitus ulcers</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>58</u> , to <u>Oct 20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Oct 20</u> , 19 <u>58</u> , and that death occurred at <u>6 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>E Reese Wilkens</u> M.D. | | DATE SIGNED <u>10/21/58</u> | |
| PHYSICIAN'S NAME (Type) <u>E REESE WILKENS</u> | | ADDRESS <u>Westminster Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>10/22/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u> | 22d. LOCATION (City, town, or county) (State) <u>TANEYTOWN MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Hartzler & Sons</u> | | ADDRESS <u>Union Bridge</u> | |
| 24a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u> | | DATE <u>OCT 23 '58</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11203

CERTIFICATE OF DEATH

11195

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH o. COUNTY <i>Carroll</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Carroll</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster #3</i> | c. LENGTH OF STAY IN 1b <i>74 days</i> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster #3</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <i>Stefanos Irene Stremmel</i> | | 4. DATE OF DEATH <i>Oct 27 1958</i> | |
| 5. SEX <i>f</i> | 6. COLOR OR RACE <i>Wh</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>8/13/1958</i> |
| 9. AGE (In years last birthday) yrs. <i>2</i> | | IF UNDER 1 YEAR: Months <i>14</i> Days <i>19</i> Hours <i>19</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Westminster Md #3</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>USK</i> | |
| 13. FATHER'S NAME <i>Gerald Percy Stremmel</i> | | 14. MOTHER'S MARRIED NAME <i>Karla Mae Helsky</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>at home</i> | |
| 17. INFORMANT <i>Gerald Stremmel Westminster Md #3</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>measles - pneumonia</i> <i>085.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <i>Oct 26 -</i> <i>dis Oct 27 -</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Aug 13, 1958</i> , to <i>Oct 27, 1958</i> , that I last saw the deceased alive on <i>Oct 26, 1958</i> , and that death occurred at <i>1:30 P. M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>George P. And</i> | | M.D. <i>139 Conville St</i> | |
| PHYSICIAN'S NAME (Type) <i>Harmon Pa</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | 22b. DATE THEREOF <i>10/28/58</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Black Rock</i> | 22d. LOCATION (City, town, or county) (State) <i>Black Rock & York Co</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick Buckner, Funeral Co</i> | | 24a. REC'D BY REGISTRAR <i>Arthur S. Huns</i> | |
| 24b. REGISTRAR'S SIGNATURE | | DATE <i>OCT 28 '58</i> | |

1000222XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 20&21 Film MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
235 11-17-58 and Item 2 Film 6235 10/29/58 gg
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11196

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 2yrs. 8mos. 5days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge/ Severn d. STREET ADDRESS ---- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Jeannette Middle Griffith Last Taylor | | 4. DATE OF DEATH Month October Day 19 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 20, 1879 |
| 9. AGE (In years last birthday) 79 yrs. | | IF UNDER 1 YEAR Months 02 Days X | IF UNDER 24 HRS. Hours 2 Min. 2 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY - | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Columbus Griffith | | 14. MOTHER'S MAIDEN NAME Emily Griffith | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. - | |
| 17. INFORMANT Springfield Hospital Records | | Address ---- | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to cause other than trauma 921.7 DUE TO Choked on Piece of cake Conditions, if any, which gave rise to immediate cause (b) - (c) - PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Involuntional psychotic reaction. Pulmonary tuberculosis. | | | INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient choked on a piece of cake. | |
| 20c. TIME OF INJURY Month, Day, Year Hour 4:15 AM Oct 19-1958 P. M. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Springfield State Hosp. | | 20f. (City or town) Carroll (County) Md. (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE W. Glenn Speicher | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Dr. W. Glenn Speicher acting | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10/23/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Friendship | | 22d. LOCATION (City, town, or county) Anne Arundel Co. (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hopping & Karkley, Glen Burnie, Md | | 24a. REC'D BY REGISTRAR DATE OCT 23 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kross | | | |

MEDICAL CERTIFICATION

11/10
15

I

06

2

BP

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11197

Reg. Dist. No.

11205

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u> | | c. LENGTH OF STAY IN lb <u>Life</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Westminster, Md. R. D. 2</u> | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>GOLDIA BELLE WAGNER</u> | | 4. DATE OF DEATH <u>Oct 12 1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 21, 1892</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife—Housework</u> | | 12. KIND OF BUSINESS OR INDUSTRY <u>Her own home</u> | |
| 13. FATHER'S NAME <u>Elias G. Shipley</u> | | 14. MOTHER'S MAIDEN NAME <u>Virginia Pickett</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Paul W. Wagner</u> Address <u>Paul W. Wagner, Westminster, Md. R. D. 2</u> | | | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>260X</u> DUE TO (b) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>min.</u> <u>years.</u> |
|--|--|--|

| | | |
|---|--|--|
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|---|--|--|

| | | | |
|---|--|--|--------------------------------------|
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |

| | |
|---|--|
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | |
|---|--|

| | | |
|--|---|-----------------------------|
| ACTUAL SIGNATURE <u>James T. Marsh</u> | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | DATE SIGNED <u>10/12/58</u> |
| EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u> | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |

| | | | |
|---|-----------------------------------|---|--|
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>10/15/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Zion Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Nr. Westminster, Carroll Co., Md.</u> |
|---|-----------------------------------|---|--|

| | | |
|---|--|---|
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u> ADDRESS <u>Littlestown, Pa.</u> | 24a. REC'D BY REGISTRAR DATE <u>OCT 14 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> |
|---|--|---|

11805

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF DEATH

PLACE OF DEATH

CITY

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

11166

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|---------------------------|--|---------------------------------------|--|-----------------|--|------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 Westminster</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u> | | | | e. STREET ADDRESS <u>141 Bishop Ct</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>REBECCA - A - WAGNER</u> First Middle Last | | | | 4. DATE OF DEATH <u>Oct 4 - 1958</u> Month Day Year | | | |
| 5. SEX <u>♀</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 10 - 1863</u> | 9. AGE (In years last birthday) <u>95</u> yrs. | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Elijah Leppo</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Aibough</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. <u>725</u> | | 17. INFORMANT <u>Mrs Chas Maucha - Westminster Md</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Cerebral thrombosis</u> DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 30, 1958</u> to <u>Oct 4, 1958</u> , that I last saw the deceased alive on <u>Oct 2, 1958</u> , and that death occurred at <u>9 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>E. Reese Wilkens</u> | | | | ADDRESS (Street, city or town, state) <u>15 Kemper av. Westminster Md</u> | | | |
| PHYSICIAN'S NAME (Type) <u>E. REESE WILKENS</u> | | | | DATE SIGNED <u>md 58</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>Oct 7 - 1958</u> | | <u>Wesley</u> | | <u>Carroll co Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Chpton Hempstead Md</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR DATE <u>OCT 8 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u> | |

11206

CERTIFICATE OF DEATH

11199

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 40 y. 2 m. 2d. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 2103.2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Henry Newton Wishard | | | | 4. DATE OF DEATH Month Day Year October 24 19 58 | | | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH unknown | |
| 9. AGE (In years last birthday) 85 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY - | | 11. BIRTHPLACE (State or foreign country) Maryland | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME Joseph Wishard | | | | 14. MOTHER'S MAIDEN NAME Rebecca Holbrenner | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - | | 16. SOCIAL SECURITY NO. - | | 17. INFORMANT Springfield Hospital Records | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 002X (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type. Pulmonary tuberculosis, far advanced, active. | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) Springfield State Hospital | | | | 20g. (County) Waynesboro | | 20h. (State) Penna. | |
| 21. I certify that I attended the deceased from 10/20/54 , 19____, to 10/24/58 , 19____, that I last saw the deceased alive on 10/24/58 , 19____, and that death occurred at 3:10 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 10/24/58 | | | | | | | |
| ACTUAL SIGNATURE Julian Radzykewicz, M.D. | | | | PHYSICIAN'S NAME (Type) Julian Radzykewicz, M.D. Sykesville, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Oct. 28, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery | | 22d. LOCATION (City, town, or county) (State) Waynesboro Penna. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE S. Marlin Poe ADDRESS Waynesboro, Penna. | | | | 24a. REC'D BY REGISTRAR DATE OCT 27 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Huns | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11200

11100

| | | | | | |
|--|--|--|--|---|--|
| <p>1. NAME OF DECEASED [Name of deceased]</p> | | <p>2. SEX [Sex]</p> | | <p>3. AGE [Age]</p> | |
| <p>4. DATE OF DEATH [Date of death]</p> | | <p>5. TIME OF DEATH [Time of death]</p> | | <p>6. PLACE OF DEATH [Place of death]</p> | |
| <p>7. CAUSE OF DEATH [Cause of death]</p> | | <p>8. MANNER OF DEATH [Manner of death]</p> | | <p>9. SIGNATURE OF PHYSICIAN [Signature]</p> | |
| <p>10. SIGNATURE OF REGISTRAR [Signature]</p> | | <p>11. SIGNATURE OF WITNESS [Signature]</p> | | <p>12. SIGNATURE OF DECEASED [Signature]</p> | |